REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Allen Anthony		40428-053
4. HOME ADDRESS (Number, Street or RFD, city or town, State and ZIP Code)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
30th legion St Brooklyn, N.Y	A+O	9-7-94

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	Black			BOP	FCI McKean

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
5-2-46	Jamaica	

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
P.O. Box 5000, Bradford, PA 16701	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	✓
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities,etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, Fistulas) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
✓	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

① Nose: 1cm scar on anterior aspect due to trauma 8 years ago.

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

	1	2	3
Restorable Teeth	32	31	30
		0	
Non-restorable teeth	32	31	30
		/	
Missing Teeth	32	31	30
		x	
Replaced by Dentures	x 32 x	x 31 x	x 30 x
Fixed Partial dentures	(32)	x 31	(30)
		(x	

RIGHT																	LEFT
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
6'0	204	Brown	Brown	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	95.0

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A SITTING	SYS 130 DIAS 90	B. RECUMBENT	SYS. DIAS	C STANDING (5 min.)	SYS DIAS	A. SITTING 84/min	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S	CX	CORR. TO	BY

62. HETEROPHORIA (Specify distance)

ES°	EX°	R.H.	L.H.	PRISM DIV	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

① Hypertension since 8 years

② T.B. : denied
HIV : denied
Hepatitis: denied
IVDA : denied

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

① Hypertension

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

None

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (Check)

A. ☒ IS QUALIFIED FOR Regular Duty

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Evan Connelly	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
[illegible] SOM MD	
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate whether)	SIGNATURE
MEDICAL DIRECTOR	
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

☆U.S. GOVERNMENT PRINTING OFFICE: 1993-342-199/50177

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Allen, Anthony		40428-053
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
289 Empire Blvd Brooklyn, NY 11224	Medical Rulah	16 Oct 92

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE	10. AGENCY	11. ORGANIZATION UNIT
Male	Black	MILITARY N/A CIVILIAN	BOP	MCC NY

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
2 Aug 64 (28)	KINGSTON, JAMAICA	ALLEN, Diana same as #4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
MCC - NEW YORK HEALTH SERVICES UNIT 150 PARK ROW NEW YORK, NEW YORK 10007	
17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total) / LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities, etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)*

BBR,

rectal - deferred

1 1/2" eliptical scar - old - (L) arm

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth — Non-restorable teeth — Missing Teeth — Replaced by Dentures — Fixed Partial dentures

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

NSN 7540-00-634-4038
88-122

Standard Form 88 (Rev. 3-89)
General Services Administration
Interagency Comm. on Medical Record
FIRMR (41CFR) 201-45.505

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
5' 11"	202	Bleach Brown	Brown	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.8

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS	B. RECUMBENT	SYS	C. STANDING (5 min.)	SYS	A. SITTING 70	B. AFTER EXERCISE	C. 3 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
	DIAS		DIAS		DIAS					

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S	CX	CORR. TO	BY

62. HETEROPHORIA *(Specify distance)*

ES°	EX°	R.H.	L.H.	PRISM DIV	PRISM CONV. CT	PD	PD

63. ACCOMMODATION		64. COLOR VISION *(Test used and result)*	65. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT	LEFT	Ishihara		CORRECTED
66. FIELD OF VISION		67. NIGHT VISION *(Test used and score)*	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

HOSP None PSY HX None

ALLERGY None PMH None

DRUG HX None PSH None

MEDICATION None ALCOHOL HX Occasional

OTHER: specify *(Use additional sheets if necessary)* None

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

ers healthy male

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

None

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE *(Check)*

A. ☒ IS QUALIFIED FOR general assignment

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN ROBERT TASSINARI PHYSICIAN ASSISTANT M.C.C., NEW YORK — SIGNATURE

80. TYPED OR PRINTED NAME OF PHYSICIAN — SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* MARK E. GLOVER M.D. — SIGNATURE

82. TYPED OR PRINTED NAME OR REVIEWING OFFICER OF APPROVING AUTHORITY MARK E. GLOVER M.D. CLINICAL DIRECTOR MCC - NEW YORK — SIGNATURE — NUMBER OF ATTACHED SHEETS

☆U.S. Government Printing Office: 1989-262-081/90235

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
DREW, A.	4	40428053

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	B			DOJ	BOP

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
5-2-64		

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
FMC-FTW	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities,etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, Fistular) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth (0) · Non-restorable teeth (/) · Missing Teeth (X) · Replaced by Dentures (X) · Fixed Partial dentures (X)

RIGHT																	LEFT
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

DISTRESS EXAM WAIVED

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
73 11	215 lbs	BLACK	BROWN	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	97.6

57. BLOOD PRESSURE *(Arm at heart level)* 58. PULSE *(Arm at heart level)* 80 REG

A. SITTING	SYS. 146 DIAS 84	B. RECUMBENT	SYS. DIAS	C. STANDING (5 min.)	SYS. DIAS	A. SITTING 96 R	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S	CX	CORR. TO	PY
LEFT 20/	CORR. TO 20/	BY	S	CY	CORR. TO	BY

62. HETEROPHORIA *(Specify distance)*

ES°	EX°	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION RIGHT	LEFT	64. COLOR VISION *(Test used and result)*	65. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED / CORRECTED

66. FIELD OF VISION	67. NIGHT VISION *(Test used and score)*	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

① DJ 1984
② INFERTILITY & SUBSTANCE ABUSE
③ TB
④ NKA

① HTN & EMOS. W/ CATAPRES 0.1MG BID
② ⊕ PPD 1993 W/ INH COMPLETED TWICE (1993

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

① HTN
② ⊕ PPD (W/ COMPLETED 1993)
③ DJ 1984

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

MAINTAIN PRESENT W/ REGIMEN

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE *(Check)*

A. ☒ IS QUALIFIED FOR REG DUTY
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

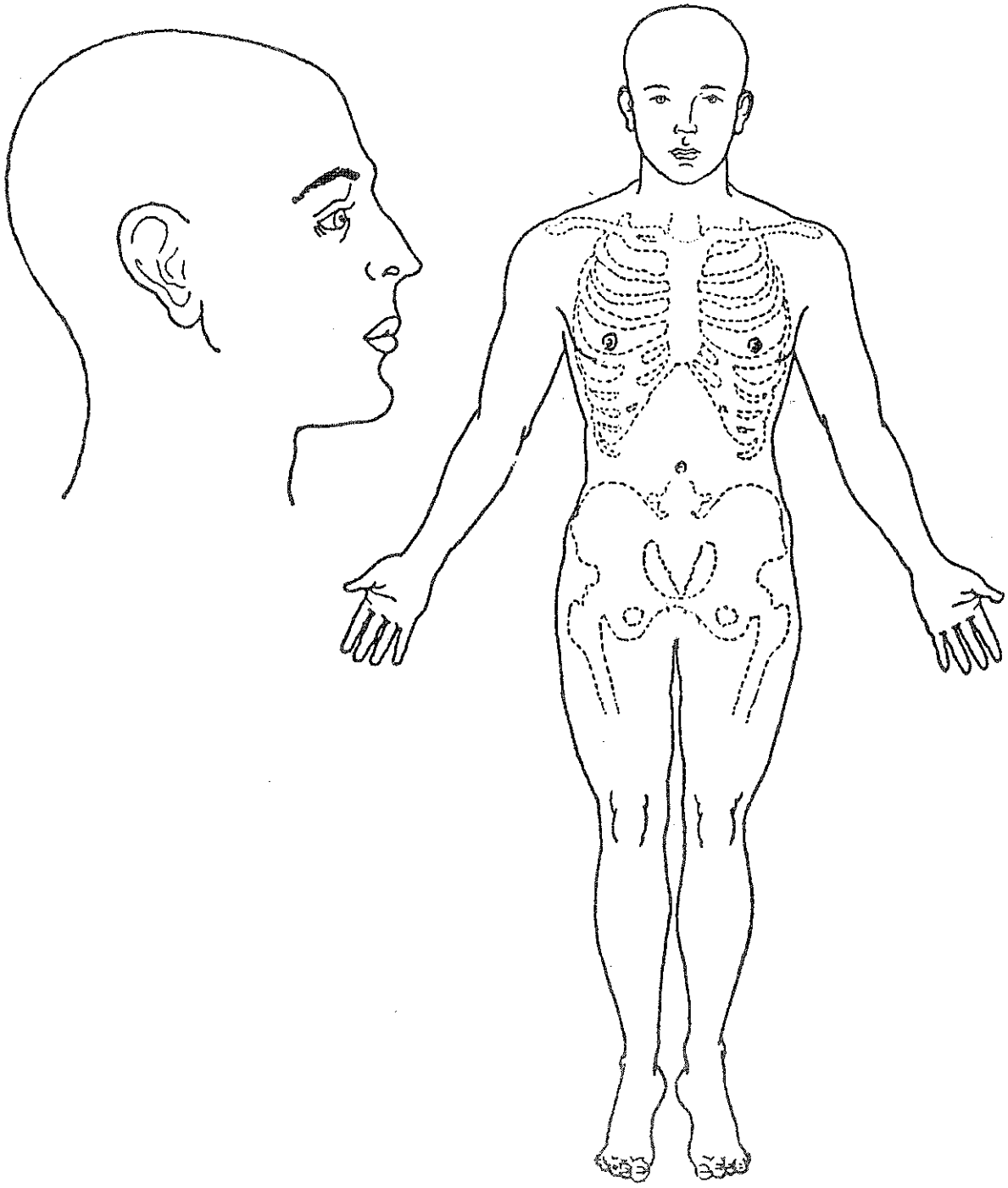
79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
J. GUARNERI. PA.	
80. TYPED OR PRINTED NAME OF PHYSICIAN B. EZAZ, M.D.	SIGNATURE B. EZAZ MD
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* BRENDA BURGES, D.D.S.	SIGNATURE Brenda A. Burges DDS
82. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

*U.S. Government Printing Office: 1991 — 281-782/40135

531-110

NSN 7540-00-634-4274

MEDICAL RECORD | **ANATOMICAL FIGURE**



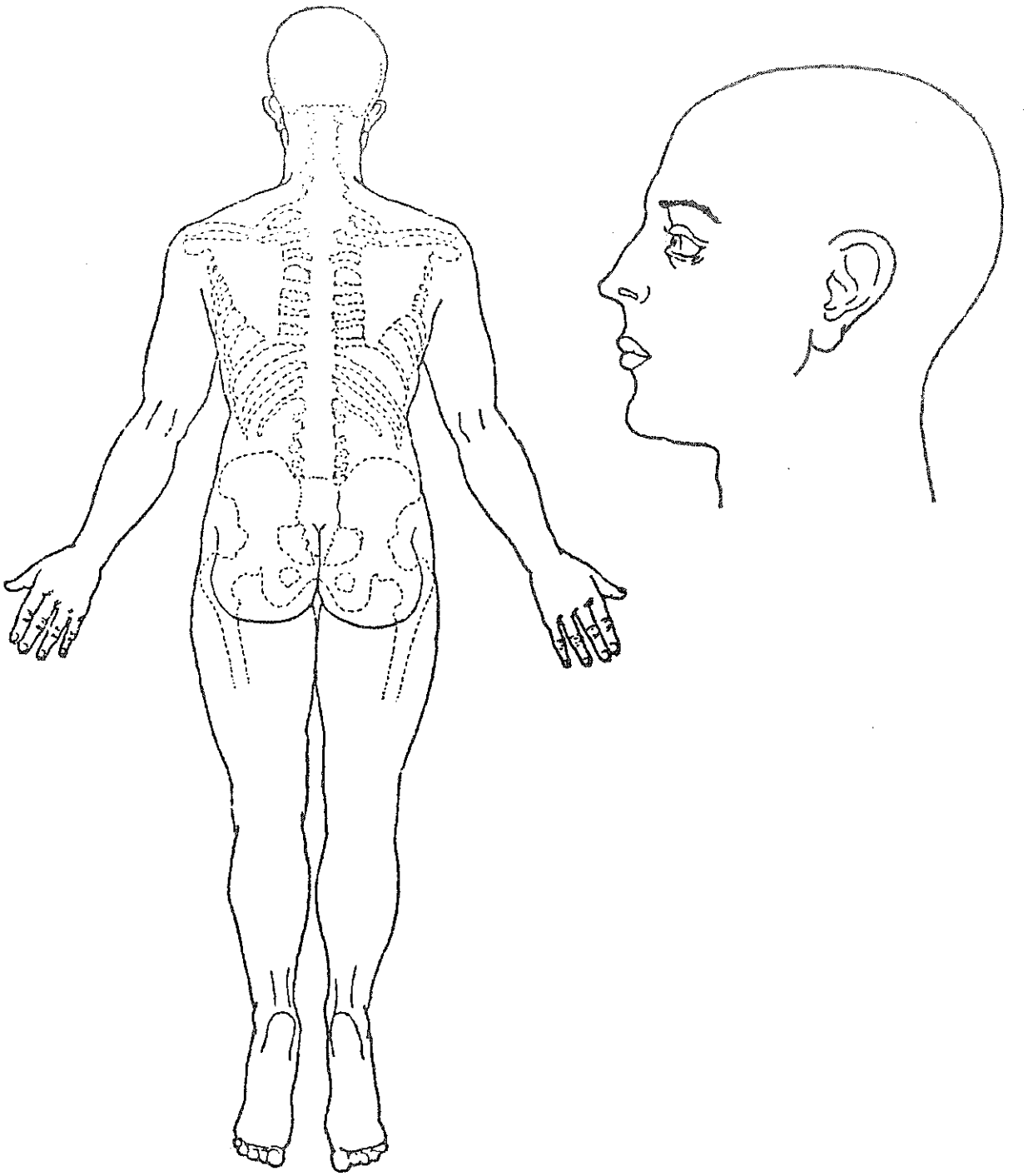
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)*

REGISTER NO.	WARD NO.
40428-053	

Allen, Anthony

ANATOMICAL FIGURE

STANDARD FORM 531 (Rev. 4-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1



U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

Allen i

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Allen, [illegible] J	[illegible]

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
INTAKE SCREEN	8-25-94	FCI MORGAN HEALTH SERVICES

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

HTN – 7 mos.
Med - Clonidine 0.1 BID
"use to have headaches but none for a couple mos"
"Does not need pain med"

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	/	Lived with anyone who had tuberculosis
	/	Coughed up blood
	/	Bled excessively after injury or tooth extraction
	/	Attempted suicide
	/	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	/	Wear glasses or contact lenses
/		Have vision in both eyes
	/	Wear a hearing aid
	/	Stutter or stammer habitually
	/	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	/		Scarlet fever		/		Adverse reaction to serum drug		/		Epilepsy or fits
	/		Rheumatic fever		/		or medicine		/		Car, train, sea or air sickness
	/		Swollen or painful joints		/		Broken bones		/		Frequent trouble sleeping
	/		Frequent or severe headache		/		Tumor, growth, cyst, cancer		/		Depression or excessive worry
	/		Dizziness or fainting spells		/		Rupture/hernia		/		Loss of memory or amnesia
		/	Eye trouble "WHEN I READ"		/		Piles or rectal disease		/		Nervous trouble of any sort
	/		Ear, nose, or throat trouble		/		Frequent or painful urination		/		Periods of unconsciousness
			Hearing loss		/		Bed wetting since age 12				Have you ever had
	/		Chronic or frequent colds		/		Kidney stone or blood in urine		/		homosexual contact?
	/		Severe tooth or gum trouble		/		Sugar or albumin in urine		/		Been exposed to AIDS
	/		Sinusitis		/		VD—Syphilis, gonorrhea, etc.		/		Alcohol Use (Excessive)
	/		Hay Fever		/		Recent gain or loss of weight		/		Drug Use/Addiction
	/		Head injury		/		Arthritis, Rheumatism, or Bursitis		/		Marijuana
	/		Skin diseases		/		Bone, joint or other deformity		/		Cocaine
	/		Thyroid trouble		/		Lameness		/		Heroin
	/		Tuberculosis		/		Loss of finger or toe		/		L.S.D.
	/		Asthma		/		Painful or "Trick"shoulder or elbow		/		Amphetamines
	/		Shortness of breath		/		Recurrent back pain		/		Others: (Specify)
	/		Pain or pressure in chest		/		"Trick" or locked knee		/		
	/		Chronic cough		/		Foot trouble		/		Alcohol or drug
	/		Palpitation or pounding heart		/		Neuritis		/		Withdrawal Problems
	/		Heart trouble		/		Paralysis (include infantile)		/		
			High or low blood pressure ON MED SEE ABOVE								
	/		Cramps in your legs								
	/		Frequent indigestion								
	/		Stomach, liver, or intestinal trouble								
	/		Gall bladder trouble or gallstones								
	/		Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

		Been treated for a female disorder
		Had a change in menstrual pattern
		ARE YOU PREGNANT
		SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

Construction

12. ARE YOU (Check one)

☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	/	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		/	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	/	B. Inability to perform certain motions.		/	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	/	C. Inability to assume certain positions.		/	
	/	D. Other medical reasons *(If yes, give reasons.)*		/	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	/	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		/	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	/	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		/	
	/	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*		/	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	/	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		/	

EXPLANATION: (#13–22 ABOVE)

DO YOU HAVE

Frequent Colds	X No	___ Yes
Thrush	X No	___ Yes
Night Sweats	X No	___ Yes
Diarrhea	X No	___ Yes
Skin Rashes	X No	___ Yes

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: ALLEN, ANTHONY

SIGNATURE: Anthony Allen

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ___ P.V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ___

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO X

WHAT ARRANGEMENTS HAVE BEEN MADE? ___

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___

GENERAL POPULATION ___ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

HTN

Medications	___ No	✓ Yes for HTN?
Allergies	X No	___ Yes
Medical Complaints	X No	___ Yes
[illegible]	X No	___ Yes
[illegible]	X No	___ Yes
Suicidal thoughts	X No	___ Yes

Medications: Clonidine for HTN?
Allergies:
Alcohol/drug/tobacco use:
Serious illness/operations:
Venereal disease/homosexuality:
Hx of hepatitis:
Significant family hx:

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
A. F GUNTHER M D	8-25-94		

REVERSE

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

(THIS INFORMATION IS FOR OFFICIAL AND MEDICAL CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME		2. REGISTER NUMBER
[illegible]		40628-053
3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINATION FACILITY
	12/10 [illegible]	

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATION CURRENTLY USED (Follow by description of past history, if complaint arises)

N/A

7. HAVE YOU EVER (Please check each item)			8. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis	✓		Wear glasses or contacts lens
	✓	Cough up blood	✓		Have vision in both eyes
	✓	Bled excessively after injury or tooth extraction		✓	Wear hearing aid
	✓	Attempted suicide		✓	Stutter or stammer habitually
	✓	Been a sleepwalker		✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever				Adverse reaction to		✓		Epilepsy or fits
	✓		Rheumatic fever				drug or medicine		✓		Car, train, sea or air sickness
			Swollen or painful		✓		Broken bones		✓		Frequent trouble sleeping
	✓		joints		✓		Tumors, growth, cyst, cancer		✓		Depression or excessive worry
			Frequent or severe	✓			Rupture/hernia		✓		Loss of memory or amnesia
	✓		headache		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Dizziness or fainting		✓		Frequent or		✓		Periods of unconsciousness
	✓		spells		✓		painful urination		✓		Have you ever had
	✓		Eye trouble		✓		Bed wetting since age 12		✓		homosexual contact?
	✓		Ear, nose, throat trouble		✓		Kidney stone or		✓		Been exposed to AIDS
	✓		Hearing loss		✓		blood in urine		✓		Alcohol Use (Excessive)
	✓		Chronic, frequent colds		✓		Sugar, albumin in urine		✓		Drug Use/Addiction
	✓		Severe tooth, gum trouble		✓		VD-Syphilis, gonorrhea,		✓		Marijuana
	✓		Sinusitis		✓		etc.		✓		Cocaine
	✓		Hay Fever		✓		Recent gain or loss of		✓		Heroin
	✓		Head injury		✓		weight		✓		L.S.D.
	✓		Skin disease		✓		Arthritis, Rheumatism,		✓		Amphetamines
	✓		Thyroid trouble		✓		or Bursitis		✓		Others: (Specify)
	✓		Tuberculosis		✓		Bone, joint or		✓		
	✓		Asthma		✓		other deformity		✓		Alcohol or drug
	✓		Shortness of breath		✓		Lameness		✓		Withdrawal Problems
	✓		Pain, pressure in chest		✓		Loss of finger or toe		✓		

This form may be replicated via WP)

This form replaces BP-360(60) dated January 1986

FTCOKL-01

			Severe headaches				Internal or "Trick"					
			Palpitation or pounding				shoulder or elbow				10. FEMALES ONLY HAVE YOU EVER	
			heart				Recurrent back pain				Been treated for a	
			Heart trouble				"Trick" or locked				female disorder	
			High or Low blood				Foot trouble				Had a change in	
			pressure				Neuritis				menstrual pattern	
			Cramps in your legs				Paralysis (include				ARE YOU PREGNANT	
			Frequent indigestion				infantile)				SUSPECT YOU ARE	
			Stomach, liver, or				Gall bladder trouble				PREGNANT	
			intestinal trouble				or gallstones					
			Jaundice or hepatitis									

11. WHAT IS YOUR OCCUPATION?

12. ARE YOU (check one) ☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or bee unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury notes? (If yes, specify when, where, and give details.)
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
		C. Inability to assume certain positions.			
		D. Other medical reasons (If you, give reasons.)			
		14. Have you, ever been treated for mental condition? (If yes, specify when, where, and give details.)			20. Have you ever been rejected for military service because of physical, mental or other reason? (If yes, give date, and reason for rejections>)
		15. Have you ever been denied life insurance? Reason give details.)			21. Have your ever been discharged from military service because of physical mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, what amount, when, why.)
		17. Have you ever been a patient in any type of hospital? (If yes, specify when, where why, and name of doctor and complete address of hospital.)			

I certify that I have reviewed the forgoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of my doctors, hospitals, or clinics mentioned above to furnish the government a complete transcript of my medical record.

TYPED OR PRINTED NAME OR EXAMINEE | SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT _____ TRANSFER _____ P.V. _____

OTHER _____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HON LONG HOW MUCH, HOW OFTEN HOW USED. WHEN WERE THEY LAST USED:

HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? _____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES _____ NO _____

WHAT ARRANGEMENTS HAVE BEEN MADE? _____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED _____

GENERAL POPULATION: _____ YES _____ NO _____

TYPE EXTENT OF LIMITATION _____

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Mark Glover NR-EMT-P Federal Transfer Center, OK			

Food or Drug Allergies: NKA: Allergies: _____

Current Medical Status: No Complaints: Complaint of _____

TB Signs and Symptom(s): None: Cough, hemoptysis, night sweats, wt. loss

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
[illegible]	[illegible]

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Screening	8/22/94	USP Lewisburg Health Services Unit Lewisburg, PA 17837

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

[illegible] medical problems

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
	✓	Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever				or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine		✓		homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain		✓		Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee		✓		
	✓		Chronic cough		✓		Foot trouble		✓		Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis		✓		Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)		✓		
	✓		High or low blood pressure		✓				✓		
	✓		Cramps in your legs		✓			10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion		✓				✓		Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble		✓				✓		Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones		✓				✓		ARE YOU PREGNANT
	✓		Jaundice or hepatitis		✓				✓		SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*			20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13–22 ABOVE)

No medical Care wanted
HTN

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ✓ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NO

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? NONE

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION NONE

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

Clonidine (Catapres) 0.1 mg
5 p.o. BID

Medications
Allergies
Medical Complaints
Evidence of Lice
Drug Use
Tuberculosis

Yes ___ No
Yes ___ No
Yes ___ No
Yes ___ No
Yes ___ No
Yes ___ No

DO YOU HAVE
Frequent Colds
Thrush
Night Sweats
Diarrhea
Skin Rashes

No ___ Yes
No ___ Yes
No ___ Yes
No ___ Yes
No ___ Yes

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
ATUL CHOPRA FMG-PA	8/26/04	Luis Martinez-Duran Physician Assistant	

REVERSE

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER	
3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever
			Rheumatic fever
			Swollen or painful joints
			Frequent or severe headache
			Dizziness or fainting spells
			Eye trouble
			Ear, nose, or throat trouble
			Hearing loss
			Chronic or frequent colds
			Severe tooth or gum trouble
			Sinusitis
			Hay Fever
			Head injury
			Skin diseases
			Thyroid trouble
			Tuberculosis
			Asthma
			Shortness of breath
			Pain or pressure in chest
			Chronic cough
			Palpitation or pounding heart
			Heart trouble
			High or low blood pressure
			Cramps in your legs
			Frequent indigestion
			Stomach, liver, or intestinal trouble
			Gall bladder trouble or gallstones
			Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
			Adverse reaction to serum drug or medicine
			Broken bones
			Tumor, growth, cyst, cancer
			Rupture/hernia
			Piles or rectal disease
			Frequent or painful urination
			Bed wetting since age 12
			Kidney stone or blood in urine
			Sugar or albumin in urine
			VD—Syphilis, gonorrhea, etc.
			Recent gain or loss of weight
			Arthritis, Rheumatism, or Bursitis
			Bone, joint or other deformity
			Lameness
			Loss of finger or toe
			Painful or "Trick"shoulder or elbow
			Recurrent back pain
			"Trick" or locked knee
			Foot trouble
			Neuritis
			Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
			Epilepsy or fits
			Car, train, sea or air sickness
			Frequent trouble sleeping
			Depression or excessive worry
			Loss of memory or amnesia
			Nervous trouble of any sort
			Periods of unconsciousness
			Have you ever had homosexual contact?
			Been exposed to AIDS
			Alcohol Use (Excessive)
			Drug Use/Addiction
			Marijuana
			Cocaine
			Heroin
			L.S.D.
			Amphetamines
			Others: (Specify)
			Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	/	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	/	B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	/	C. Inability to assume certain positions.			
	/	D. Other medical reasons *(If yes, give reasons.)*			
	/	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		/	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	/	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		/	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	/	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	/	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR' MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED; HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION / YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

RECEIVED THIS DATE
F.C.I. EL RENO, OK.
NO MEDICAL COMPLAINTS
WILL CONTINUE RECOMMENDATIONS

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
PHYSICIA... FEDERAL CORR... EL RENO, OKLAHOMA	AUG 12 1994		

REVERSE

U.S. Department of Justice — MEDICAL HISTORY REPORT

Federal Bureau Of Prisons

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Allen Anthony G	40428-053

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Safe Ke Screen	6-16-94	FMC - Ft Worth

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

Cafergot B.I.D. mg (?)

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever				Adverse reaction to serum drug		✓		Epilepsy or fits
			Rheumatic fever				or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones			✓	Frequent trouble sleeping
			Frequent or severe headache		✓		Tumor, growth, cyst, cancer			✓	Depression or excessive worry
✓			Dizziness or fainting spells			✓	Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had homosexual contact?
✓			Chronic or frequent colds		✓		Kidney stone or blood in urine				
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
			Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
		✓	Thyroid trouble			✓	Lameness		✓		Heroin
			Tuberculosis		✓	✓	Loss of finger or toe		✓		L.S.D.
		✓	Asthma			✓	Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath			✓	Recurrent back pain				Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble				Alcohol or drug Withdrawal Problems
	✓		Palpitation or pounding heart		✓		Neuritis		✓		
	✓		Heart trouble		✓		Paralysis (include infantile)				
✓			High or low blood pressure								
		✓	Cramps in your legs								
		✓	Frequent indigestion								
✓	✓		Stomach, liver, or intestinal trouble								
✓	✓		Gall bladder trouble or gallstones								
✓	✓		Jaundice or hepatitis.								

10. FEMALES ONLY HAVE YOU EVER

	✓		Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR ~~USUAL OCCUPATION~~?

Prof

12. ARE YOU (Check one)

☑ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER N.C.

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED Lower bunk

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION Lower bunk

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

1- NKDA
2- Operation - NO
3- Fx - NO
4- Dep - NO
5- Drugs - NO
6. Etoh - NO
7- Drug - Social
8- STD - NO
9. No LOC
10. Hx HTN

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
KAKAS, E.F. PA	6-10-94	E.F.	

REVERSE

STANDARD FORM 93
REV. OCTOBER 1974
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29- R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*	**4. POSITION** *(title, grade, component)*
229 [illegible] Ave 11105	Non
5. PURPOSE OF EXAMINATION	**6. DATE OF EXAMINATION**
Enrolled Reserve	16 Oct 92

7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
[illegible] - NEW YORK
HEALTH SERVICES UNIT
150 PARK ROW
NEW YORK, NEW YORK 10007

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past illness if complaint exists)*

I am in good health
NO medication

9. HAVE YOU EVER *(Please check each item)*			10. DO YOU *(Please check each item)*	
YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
		Lived with anyone who had tuberculosis			Wear glasses or contact lenses
		Coughed up blood			Have vision in both eyes
		Bled excessively after injury or tooth extraction			Wear a hearing aid
		Attempted suicide			Stutter or stammer habitually
		Been a sleepwalker			Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug, or medicine				Car, train, sea or air sickness
			Ear, nose, or throat trouble								Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD—Syphilis, gonorrhea, etc.				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?
IT

14. ARE YOU *(Check one)*
☑ Right handed ☐ Left handed

93-103

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	✓	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
	✓	B. Inability to perform certain motions.
	✓	C. Inability to assume certain positions.
	✓	D. Other medical reasons (*If yes, give reasons.*)
	✓	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.*)
	✓	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
	✓	18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
	✓	19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
	✓	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
	✓	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
	✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
	✓	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)
	✓	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in Items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

ears healthy male
& medication

ROBERT TASSINARI
PHYSICIAN ASSISTANT
M.C.C., NEW YORK

16 Oct 97

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
ANTHONY [illegible]	15/16		

REVERSE OF STANDARD FORM 93

☆U.S.GPO:1986-0-181-247/40193